MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2004

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, IL 62439-2395

NAIC Group Code 0263
NAIC Company Code 62286

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, IL 62439-2395

MARKET CONDUCT EXAMINATION REPORT as of December 31, 2004

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

June 10, 2005

The Honorable David F. Rivera
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Rivera:

This limited market conduct examination of Golden Rule Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health insurers. We examined the Company's records at its office located at 713 Thirteenth Street, Lawrenceville, IL 62439-2395. The market conduct examination covered the period from January 1, 2004 through December 31, 2004.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT EXAMINATION REPORT OF GOLDEN RULE INSURANCE COMPANY

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COMPANY PROFILE

On November 14, 2003, Golden Rule Financial and its subsidiaries merged with UnitedHealth Group and Golden Rule Insurance Company is now a wholly owned subsidiary of UnitedHealth Group. The Company is licensed to market insurance in all states and the District of Columbia with the exception of New York State. The Company offers group and individual health insurance, group and individual life insurance, individual life-based long-term care policies, individual annuity-based long-term care policies, and individual annuities. The vast majority of its business is generated through a large network of independent brokers as well as sponsored marketing agreements with major life insurance companies.

Golden Rule began its operations in Colorado on December 26, 1979. It is licensed to market health, life, and annuities in Colorado. In the health market, the Company offers hospitalization, long-term medical, and HSA's to Colorado residents for application through an out-of-state association group master policy.

The Company began on November 16, 1940, by founders M.A. and Mary Rooney in Lawrenceville, Illinois with a permit to sell applications for a burial society known as Golden Rule Insurance Association. On January 27, 1942, Golden Rule became an assessment legal reserve company and the name was changed to Golden Rule Life Insurance Company. In 1946, the Company's charter was amended to include accident and health insurance in addition to life insurance.

In 1961 a second company (St Anthony Life) was formed. The corporate name was changed the following year to Congressional Life Insurance Company. Congressional specialized in disability income and life insurance. In 1964, the following four (4) new companies were formed: AdVentures, Executive Systems, Data Service Corporation, and Insurance Administrative Corporation. These companies provided services, support, and consulting services.

In 1977, Congressional Life Insurance Company changed its name to Golden Rule Insurance Company to unify the identity of the two insurance companies. Executive Systems became Golden Rule Financial Corporation, the parent holding company of both insurance companies and other service subsidiaries.

In March 1980, Golden Rule Life Insurance Company and Golden Rule Insurance Company merged to form the single company of Golden Rule Insurance Company. Golden Rule expanded to Indianapolis, IN, with certain "sister" operations in 1983. In 1984 a new division (Financial Services) was added to concentrate on life and annuities.

In 1986, Golden Rule began entering into "sponsored" marketing agreements with other companies. These agreements allowed these other companies' sales forces to market certain Golden Rule products that they did not market themselves.

In March 2001, Golden Rule set aside 48% of Golden rule stock thereby creating an ESOP by which the employees became partial owners of the Company.

The Company's 2003 direct written premium for accident and health plans in Colorado was $43,135,000 representing 1.81 % of the market share.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Golden Rule Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to association group sickness and accident insurance laws. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2004 through December 31, 2004.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

For the period under examination, the examiners included statutory citations and regulatory references related to group insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-7-109	Suicide no defense for nonpayment
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-123	Telemedicine
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Section 10-20-119	Prohibited advertisement of association article in insurance sales – notice to policyholders
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Repealed and Repromulgated Regulation 1-1-7	Market Conduct Record Retention
Repromulgated Regulation 4-2-1	Replacement Of Accident And Sickness Insurance
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Amended Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Regulation 4-2-15	Required Provisions in Carrier Contracts With Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans

Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Amended Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations
New Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
New Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Applications, Endorsements and Rider Forms:

FORM NUMBER	FORM NAME
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: Federation of American Consumers and Travelers (FACT)
SA-S-1026	Colorado Endorsement
9377-7/5/2001	Summary of the Life and Health Insurance Protection Association Act and Notice Concerning Coverage Limitations and Exclusions
GRI-AP-107-05	Application For Insurance
AP-REIN-112-05	Application For Reinstatement Of
None	CoverColorado Plan Notice Form
None	Certificates of Creditable Coverage
6-C-410	Supplemental Accident Expense Benefits
SA-S-313(c)	Decreasing Term Life Insurance Rider

The most frequently sold plan in Colorado in 2004 was Certificate Form Number C-006.4-05, association group coverage, with the master policy being issued to the Federation of American Consumers and Travelers.

Rating

The examiners reviewed a randomly selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

The Company's individually underwritten association group plans are issued for an indefinite term. As a result there were no renewable term plans or certificates to report for the year under examination. For cases that were initially effective in 2004 or issued with indefinite terms prior to the period from January 1, 2004 through December 31, 2004, the examiners used ACL ™ software to randomly select one hundred individual application files. The Company furnished a listing of 6,745 application files and the sample of one hundred was selected from this population.

Cancellations/Non-Renewals/Declinations/Rescissions

For these association group cases that terminated (cancelled, non-renewed, were rescinded or declined) during the period under examination, the examiners used ACL ™ software to randomly select a sample of 100 cancelled/non-renewed files and fifty (50) declined files. The population of nineteen (19) rescinded files was used as the sample. These files were reviewed to determine if the procedures used for cancellations, non-renewals, declinations and rescissions were in compliance with Colorado insurance law and contractual obligations.

Claims

The examiners used ACL ™ software to randomly select samples of electronically received and non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL ™ software to randomly select samples of 100 Paid claims and 100 Denied claims that were reviewed for the Company's overall claims handling practices.

Utilization Review

Golden Rule Insurance Company does not require prospective or retrospective review of medical care or medical services. The plans contain a notification provision that requires the covered person to contact the Company's notification review agent on or before the day the covered person begins the fourth day of

an inpatient hospitalization or is evaluated for an organ or tissue transplant. Additionally the Company does not offer a voluntary second level review.

The Company contracts with Encompass Health Management Systems for notification on the insurance plans that have a leased network. UnitedHealthcare Care Management is the notification review agent for the insurance plans with the Choice Plus or Options PPO networks. Care Management, the Choice Plus and Options PPO networks, and Golden Rule Insurance Company are all part of UnitedHealth Group.

The Company provided twenty-seven (27) files classified as reconsiderations in 2004 and reviewed by Encompass. This population of twenty-seven (27) was used as the sample for review. The examiners used ACL ™ software to randomly select a sample of fifty (50) files from the population of 134 cases of all utilization review conducted by Encompass and a population of thirty-six (36) cases of all utilization review conducted by Care Management in 2004. Care Management did not have any appeals for adverse determinations for the period of the examination. Populations of four (4) First Level Review Appeals, two (2) Second Level Review Appeals and two (2) Independent External Reviews handled by Encompass were provided. These populations were used as the sample. The files were reviewed for compliance with Colorado insurance law, and in addition the examiners reviewed the Company's utilization management procedures and policies.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of fifteen (15) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found one (1) area of concern in their review of company operations and management. The following issue was identified:

    - Failure to include some forms in use on the 2004 Annual Report of Forms.

  It is recommended that the Company establish procedures to ensure that all policy forms or other evidence of health care coverage currently in use are included on its Annual Report of Forms.

- **Policy Forms:** The examiners found nine (9) areas of concern in their review of the most frequently sold association group coverage forms in use during the year under examination. The following issues were identified:

    - Failure to disclose the existence and availability of an access plan.
    - Failure to reflect wording that would allow coverage for self-inflicted injuries sustained by an insane person or from death occurring as a result of an insane person taking their own life.
    - Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member.
    - Failure to reflect that repairs of prosthetic devices, unless due to misuse or loss, are to be covered.
    - Failure to reflect the coverage to be provided for inherited enzymatic disorders.
    - Failure to reflect correct information concerning pre-existing condition limitations.
    - Failure to provide coverage for court ordered substance abuse treatment.
    - Failure to reflect a correct description of the coverage to be provided for mental illness.
    - Failure to make the required offer of availability of coverage for hospice care and alcoholism.

It is recommended that the Company review and revise all applicable policy forms to ensure compliance with the requirements of Colorado insurance law.

- **Rating:** The examiners found no areas of concern in their review of the rates and associated required rate filings.

- **Applications:** The examiners found no areas of concern in their review of application files for the examination period.

- **Cancellations/Non-Renewals/Declinations:** The examiners found no areas of concern in their review of cancellations/non-renewals/declinations/rescissions.

- **Claims:** The examiners found two (2) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

    - Failure to accurately determine the number of days utilized for claim processing.

    - Failure, in some cases, to accurately process claims.

  It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time periods required by Colorado insurance law. Procedures should also be established to ensure that the number of days utilized for claim processing is calculated correctly, that late payment interest and penalties are paid in all applicable instances and claim procedures should be reviewed to ensure accuracy of benefit payments in all cases. Correct procedures should also be established to eliminate requesting any unnecessary authorizations for release of medical records.

- **Utilization Review:** The examiners found three (3) areas of concern in their review of utilization review procedures. The following issues were identified:

    - Failure to reflect complete information in materials dealing with grievance procedures.

    - Failure to include all required information in written notification of decisions for expedited and first level reviews.

    - Failure to provide correct information concerning voluntary second level reviews.

  It is recommended that procedures be corrected and monitored to ensure that Utilization Review functions are conducted in compliance with Colorado insurance law.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

GOLDEN RULE INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Failure to include some forms in use on the 2004 Annual Report of Forms.

Section 10-16-107.2, C.R.S., Filing of health policies, states:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

Amended Regulation 1-1-6, Concerning The Elements Of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Endorsement Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", states:

Section 4 Definitions

> D. "Annual Report for health coverage" shall mean a list of all *policy forms, application forms* [emphasis added] (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident, and/or health insurance policy, contract, certificate, or other evidence of coverage currently in use and issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado, including the titles of the programs or products affected by the forms.

The Company provided a copy of the 2004 Annual Report of Forms that was filed December 21, 2004, with the Division of Insurance. This report does not appear to reflect the following forms:

"Colorado Appeal Procedures Notice" of which there were the following four (4) versions used in 2004 with the most frequently sold plan.

Form Number	Edition Date	Used
34471	11/03	From 01/01/04 to 04/22/04
34471R	02/23/04	From 04/23/04 to 06/21/04
34471R	06/02/04	From 06/22/04 to 10/26/04
34471R2	08/27/04	Put into use on 10/27/04

"Health Insurance Certification And Authorization To Obtain and Disclose Information"

F063BF

"Hospital Indemnity Rider"

SA-S-1019

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107.2, C.R.S., and amended Regulation 1-1-6. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all policy forms or other evidence of health care coverage currently in use are included on its Annual Report of Forms as required by Colorado insurance law.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to disclose the existence and availability of an access plan.

Section 10-16-102, C.R.S., Definitions, states:

> 26.5) "Managed care plan" means a policy, contract, certificate, or agreement offered by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, under contract with, or employed by the carrier because the carrier either requires the use of or creates incentives, including financial incentives, for the covered person's use of those providers.

Section 10-16-704, C.R.S., Network adequacy, states:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in Section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, *all health benefit plans* and marketing materials *shall clearly disclose the existence of and availability of the access plan.* … [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its most frequently sold health benefit plan does not clearly disclose the existence and availability of an access plan for its Sloans Lake managed care and UnitedHealthcare managed care networks.

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect the existence and availability of an access plan as required by Colorado insurance law.

Issue E2: Failure to reflect wording that would allow coverage for self-inflicted injuries sustained by an insane person or from death occurring as a result of an insane person taking their own life.

Section 10-16-102, C.R.S., Definitions, states:

> (30) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both.

Bulletin 8-99, issued October 22, 1999 states:

Suicide Exclusions And Exclusions For

Intentionally Self-Inflicted Injuries In Health Insurance Policies

Section 1: Background and Purpose

The Division of Insurance ("Division") has received consumer complaints concerning some health insurance carriers' usage and interpretations of suicide exclusions and exclusions for intentionally self-inflicted injuries in their policies. Some carriers are using exclusions to deny coverage for intentionally self-inflicted injuries, including suicide or attempted suicide, even where the injury, suicide or suicide attempt may be the result of sickness, accident or illness, which is covered under the policy. The exclusions at issue use language the same or substantially similar to the following: "benefits are excluded for treatment as a result of attempted suicide or suicide or intentionally self-inflicted injury, whether sane or insane." The purpose for this bulletin is to clarify the Division's position on this issue.

Section 2: Applicability and Scope

The subject matter of this bulletin concerns all health insurance carriers that use exclusions for intentionally self-inflicted injuries, including suicide and suicide attempts in their policies.

Section 3: Division Position

The Division adheres to the opinion of the Colorado courts that suicide, attempted suicide or other acts of self-destruction committed while insane are an accident. Those performing the above acts while insane are incapable of formulating the intent necessary to categorize the act as intentional. Therefore, insurance policies that provide coverage for sickness, accidents and illness, either as may be required by law (such as for mental illness) or otherwise, may not deny coverage for intentional acts committed while insane. Such exclusions are contrary to law and are void as against public policy. Accordingly, carriers are advised to amend policy language and interpret existing policy language accordingly.

> The prevailing view in Colorado courts is that broad exclusions for self-inflicted injuries or suicide attempts may not be applied in instances in which the insured or member was "insane" at the time of injury in sickness and accident policies written in Colorado. See e.g., Continental Casualty Co. v. Maguire, 471 P.2d 636 (Colo. Ct. App. 1970); Metropolitan Life Insur. Co. v. Wright, 480 P.2d 597 (Colo. Ct. App. 1971); Mass. Protective Ass'n v. Daugherty, 288 P. 888(Colo. 1930) (life insurance policy). The reasoning applied by these courts is that injuries sustained in such circumstances are "accidents," not "intentional" acts, since an individual who is insane is incapable of forming the requisite intent.

The Company's most frequently sold policy in Colorado in 2004 has an exclusion that does not appear to be in compliance with Colorado insurance law. Intentional acts can be excluded, but if a mental condition prevents a person from forming intent, coverage for expenses resulting from self-inflicted bodily harm cannot be denied. Additionally, the Company's Decreasing Term Life Insurance Rider, available with the most frequently sold policy reflects an exclusion for paying life insurance benefits if the covered person's death is a result of the person taking his or her own life, while sane or insane during the first year of coverage.

The wording in the policy under "General Exclusions and Limitations, page 29 is:

> (AH) as a result of:
>
> (1) intentionally self-inflicted bodily harm (whether the *covered person* is sane or insane);

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT

The wording on page 1 of the rider is:

> DECREASING TERM LIFE INSURANCE RIDER
>
> IF THE COVERED PERSON TAKES HIS OR HER OWN LIFE: We will not pay benefits under the provision if the covered person's death occurs as a result of the covered person taking his or her own life, while sane or insane, during the first year of continuous coverage under the policy.

Form Number	Form Name
SA-S-313(c)	Decreasing Term Life Insurance Rider

Recommendation No.3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S., and Bulletin 8-99. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect that self-inflicted bodily harm or death occurring as a result of an insane individual taking their own life cannot be denied as required by Colorado insurance law.

Issue E3: Failure to provide benefits for covered services based solely on a licensed provider's status, e.g., a family member.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers

(a) Sickness and accident insurance

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

The Company's most frequently sold plan in Colorado in 2004 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. A policy could contain an exclusion for charges that would not be billed if the member did not have insurance, but the policy may not exclude reimbursement for covered services performed by a licensed provider if the provider normally charges for the services nor can a policy deny reimbursement for covered benefits based solely upon the provider's status, e.g., immediate family member.

The wording on pages 27 and 28 of the certificate is:

GENERAL EXCLUSIONS AND LIMITATIONS
Applicable to All Benefits Except Life Insurance, If Any

… No benefits will be paid for any services performed by a member of the covered person's immediate family.

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that benefits may not be denied solely based on a provider's status, (e.g., a family member) as required by Colorado insurance law.

Issue E4: Failure to reflect that repairs of prosthetic devices, unless due to misuse or loss, are to be covered.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(14) Prosthetic devices

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(e) *Repairs* and replacements of prosthetic devices are also covered, subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added.]

The Company's most frequently sold individual plan in Colorado in 2004 does not appear to provide the mandatory coverage of repairs of prosthetic devices unless necessitated by misuse or loss.

The wording on page 16 of the certificate is:

MEDICAL BENEFITS

STANDARD MEDICAL COVERED EXPENSES:

Standard medical *covered expenses* are limited to charges:

(M) for artificial eyes or larynx, breast prosthesis or basic artificial limbs (but not the replacement thereof unless required by a physical change in the *covered person* and the item cannot be modified);

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that repairs of prosthetic devices, unless due to misuse or loss, are to be covered as required by Colorado insurance law.

Issue E5: Failure to reflect the coverage to be provided for inherited enzymatic disorders.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1)(a) All group and individual sickness and accident insurance policies and all service or indemnity contracts issued by any entity subject to part 3 or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(c)(III)(A) Coverage for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids shall include, but not be limited to, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders, hyperlysinemia; glutaric acidemias; methylmalonic academia; and propionic academia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a physician who is a participating provider has issued a written, oral, or electronic prescription.

(B) There is no age limit on benefits for inherited enzymatic disorders specified in sub-subparagraph (A) of this paragraph (III) except for phenylketonuria. The maximum age to receive benefits for phenylketonuyria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

(C) As used in this subparagraph (III), "medical foods," means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a physician who is a participating provider. This sub-subparagraph (C) shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

(D) Coverage of medical foods, as provided under this subparagraph (III), shall only apply to insurance plans that include an approved pharmacy benefit and shall not apply to alternative medicines. Such coverage shall only be available through participating pharmacy providers. Nothing in this subparagraph (III) shall be construed as

preventing a carrier from imposing deductibles, coinsurance, or other cost-sharing methods.

The Company's most frequently sold plan in Colorado in 2004 does not appear to reflect any mention of the mandatory coverage for inherited enzymatic disorders and in addition the description of covered prescription drugs appears to be limited to prescription drugs and medicines which would not include payment of benefits for "medical foods", which is one of the treatments for such conditions and is to be provided for a dependent newborn child from the moment of birth. There is no age limit on benefits except for phenylketonuria. Additionally the description of covered prescription drugs limits charges to those for which there is a written prescription. Medical foods for inherited enzymatic disorders are to be provided if a participating provider has issued a written, oral, or electronic prescription.

The wording on pages 25 and 26 of the certificate is:

OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFITS

COVERED EXPENSES: *Covered expenses* for *out-patient* prescription drugs are limited to charges from a licensed *pharmacy* for:

(A) any medication whose label is required to bear the legend "Caution: federal law prohibits dispensing without a prescription";
(B) a *prescription legend drug* for which a written prescription is required;
(C) oral or injectable insulin dispensed at the written prescription of a *doctor*, but not any device for injecting insulin;
(D) a compound medication of which at least one ingredient is a *prescription legend drug;* and
(E) any drug which, under the applicable state law, may be dispensed only upon the written prescription of a *doctor*.

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect the mandatory coverage for inherited enzymatic disorders as required by Colorado insurance law.

Issue E6: Failure to reflect correct information concerning pre-existing condition limitations.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(a)(I) If it is a *group health benefit plan, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than six months following the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment;* … A group health benefit plan may impose a preexisting condition exclusion or limitation only if such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment, … [Emphasis added.]

(b) Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. The method of crediting and certifying coverage shall be determined by the commissioner by rule.

The provision regarding reinstatement in the Company's most frequently sold plan in Colorado in 2004 does not appear to comply with Colorado insurance law in that it reflects an incorrect time frame of twelve (12) months instead of six (6) months for the qualification period that is to be used for determining when pre-existing conditions are to be covered. In addition, the Company's application used for this plan reflects a statement indicating the same incorrect time frame of twelve (12) months with regard to preexisting condition limitations. Lastly, there is no reference to the credit for previous coverage that must be provided to reduce any preexisting limitation.

The wording on page 39 of the plan is:

REINSTATEMENT

The reinstated coverage will cover loss from illness and injury. The reinstated coverage will not cover loss from:

(A) *Injury* sustained between the date coverage lapsed and the date it was reinstated; or

(B) *Illness* first manifested between the date coverage lapsed and the date it was reinstated.

Illness and *injury* of the type described in (A) and (B) above will be a *preexisting condition*. As with initial coverage under the policy, these preexisting conditions will be covered 12 months after the date of reinstatement, unless coverage of this *illness* or *injury* is restricted by rider. The incontestability clause will apply to statements made on the reinstatement application based on the date of reinstatement.

The wording on page 4 of the application is:

STATEMENT OF UNDERSTANDING: Review the completed application and read the section below carefully before signing.

I certify that I have personally completed this application. I represent that the answers and statements in this application are true, complete, and correctly recorded. **I Understand and Agree that: (2)** there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition;

Form Number	Form Name
C-006.4-05	Certificate for Policy No: G46HS12004 Policyholder: FACT
GRI-AP-107-05	Application For Insurance

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised the reinstatement provision in all applicable forms and applications to reflect the correct information concerning pre-existing condition limitations as required by Colorado insurance law.

Issue E7: Failure to provide coverage for court ordered substance abuse treatment.

Section 10-16-104.7, C.R.S., Substance abuse – court-ordered treatment coverage, states:

> (1) Any individual or group health benefit plan delivered or issued for delivery within this state by an entity subject to the provisions of part 2, 3, or 4 of this article that provides coverage for substance abuse treatment shall provide coverage for substance abuse treatment *regardless of whether the treatment is voluntary or court-ordered* as a result of contact with the criminal justice or legal system. [Emphasis added.] The health benefit plan shall only be required to provide coverage for benefits that are medically necessary and otherwise covered under the plan. Such coverage shall be subject to copayment, deductible, and policy maximums and limitations. Health benefit plans issued by an entity subject to the provisions of part 4 of this article may provide that the benefits required pursuant to this section shall be covered benefits only if the services are deemed medically necessary and are rendered by a provider who is designated by and affiliated with the health maintenance organization.

The Company's most frequently sold plan in Colorado in 2004 does not appear to be in compliance with Colorado insurance law. Coverage for substance abuse treatment has been added to the plan by a Colorado Endorsement that eliminates the general exclusion in the certificate for treatment of substance abuse, unless expressly provided for by the policy; however there is another exclusion stated in the certificate for court-ordered treatment programs for substance abuse or alcoholism.

The wording on page 11 of the certificate is:

DEFINITIONS

"*Substance abuse"* means alcohol, drug or chemical abuse, overuse or dependency.

The wording on page 28 of the certificate is:

GENERAL EXCLUSIONS AND LIMITATIONS

Covered expenses will not include, and no benefits will be paid for any charges which are incurred:

(O) for treatment of *substance abuse,* unless expressly provided for by the *policy;*

The wording on page 29 of the certificate is:

(AK) for court-ordered treatment programs for *substance abuse* or *alcoholism*.

The wording on pages 4 and 5 of the Colorado Endorsement is:

L. The General Exclusions and Limitations Section is amended to delete the exclusion for diagnosis and treatment of *substance abuse* (including *alcoholism* and to replace it with the following limited coverage:

Subject to the limitations stated below, expenses incurred for the diagnosis or treatment of substance abuse (including *alcoholism)* will be considered *covered expenses* under the *policy.*

If a *covered person* incurs expenses for the diagnosis or treatment of *substance abuse* (including *alcoholism*) while an *inpatient,* the *policy* will cover the expense to the same extent as any *illness* subject to the same exclusions, limitations and other terms, as any *illness.*

If diagnosis or treatment of *substance abuse* (including *alcoholism)* is provided to a *covered person* while an *outpatient,* then *covered expenses* for the professional fees of a *medical practitioner* will be limited to $50 per visit.

Covered expenses for substance abuse (including *alcoholism*) will be subject to all the terms, conditions, limitations and exclusions of the *policy,* including any applicable *deductible amounts,* coinsurance provisions, copayment amounts and maximum dollar limits.

Benefits for *covered expenses* for the diagnosis or treatment of *substance abuse* (including *alcoholism*) will be limited to a $3,000 per lifetime maximum per *covered person*.

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT
SA-S-1026 1/28/03	Colorado Endorsement

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104.7, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that coverage will be provided for court ordered substance abuse treatment as required by Colorado insurance law.

Issue E8: Failure to reflect a correct description of the coverage to be provided for mental illness.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (5) Mental illness
>
> Every group policy or contract providing hospitalization or medical benefits by an entity subject to the provisions of part 2 or 3 of this article shall provide benefits for conditions arising from mental illness at least equal to the following:
>
> (b)(I) In the case of major medical coverage, *benefits shall cover outpatient services* furnished by a comprehensive health care service corporation, a hospital, or a community mental health center or other mental health clinics approved by the department of human services to furnish mental health services; or furnished by a registered professional nurse within the scope of his or her license; or furnished by a licensed clinical social worker within the scope of his or her license; or furnished by or under the supervision of a licensed physician or licensed psychologist acting in compliance with part 3 of article 43 of title 12, C.R.S. …[Emphasis added.]
>
> (c) An entity subject to the provisions of part 2 or 3 of this article may establish a copayment or coinsurance requirement for mental illness, which may or may not differ from the copayment or coinsurance requirement established for any other condition or illness; except that copayment or coinsurance requirements shall not exceed a fifty percent copayment or coinsurance requirement. Such entity may establish a deductible amount for mental illness, but such deductible amount shall not differ from the deductible amount for any other condition or illness. In addition, such entity may limit the aggregate benefits payable under paragraph (b) of this subsection (5) to an amount of not less than one thousand dollars in any one twelve-month benefit period or not less than twenty visits per year.

The Company's most frequently sold plan in Colorado in 2004 does not appear to reflect correct benefits to be provided for mental illness in the following ways:

Incorrect: Reflecting that there is an aggregate limit of $3,000 total liability for all losses due to mental disorders of any one covered person in a lifetime is more limiting than allowed by Colorado insurance law. The Colorado Endorsement, page 4, indicates covered expenses for mental or nervous disorders will not be subject to the lifetime maximum amount stated in Section 1, the Data Page, but this lifetime maximum amount is also reflected in Section 6, Medical Benefits, pages 17 and 18 of the certificate.

> There is no provision in Colorado insurance law for limiting outpatient visits to $50.00 for any one visit. Outpatient services may be limited to no less than one thousand dollars in any one twelve-month benefit period *or* not less than twenty visits per year. [Emphasis added.]

The wording on page 4 of the Colorado Endorsement is:

> J., 4. *Covered expenses* for mental or nervous disorders will not be subject to the lifetime maximum amount for mental or nervous disorder benefits, if any, stated in Section 1.

The wording in Section 6, pages 17 and 18 of the certificate is:

MEDICAL BENEFITS

> **LIMITATION ON MENTAL DISORDERS AND SUBSTANCE ABUSE:** If a *covered person* incurs a *covered expense* for the diagnosis or treatment of a *mental disorder*, including *substance abuse*, or for mental incapacity while an *inpatient*, the *policy* will cover the expense the same as any other *illness*. However, *covered expenses* for the fees of any *medical practitioner* will not exceed $50 for any one outpatient visit and *our* total liability under the *policy* for all *losses* due to *mental disorders*, or mental incapacity, of any one *covered person* will not exceed $3,000 in any one *covered person's* lifetime.

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT
SA-S1026	Colorado Endorsement

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect a correct description of the coverage to be provided for mental illness as required by Colorado insurance law.

Issue E9: Failure to make the required offer of availability of coverage for hospice care and alcoholism.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(8) Availability of hospice care coverage

(II)(b) Notwithstanding any other provision of the law to the contrary, no individual or group policy of sickness and accident insurance issued by an insurer subject to the provisions of part 2 of this article and no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis *shall be sold in this state unless a policyholder under such policy or plan is offered the opportunity to purchase coverage for benefits for the costs of home health services and hospice care* which have been recommended by a physician as medically necessary. … [Emphasis added.]

(9) Availability of coverage for alcoholism

(a) Any other provision of law to the contrary notwithstanding, no hospitalization or medical benefits contract on a group basis issued by an insurer subject to the provisions of part 2 of this article or an entity subject to the provisions of part 3 of this article *shall be sold in this state unless the policyholder under such contract or persons holding the master contract under such contract are offered the opportunity to purchase coverage for benefits for the treatment of and for conditions arising from alcoholism, which benefits are at least equal to the following minimum requirements*: … [Emphasis added.]

The Company filed the HSA 100 Policy, Group Policy Number G46HS12004, for sale in Colorado as of March 1, 2004. The master policy was issued to the Federation of American Consumers and Travelers (FACT) and this plan was the most frequently sold plan in Colorado in 2004. No offer was made to the policyholder giving them the opportunity to purchase coverage under this policy for benefits for the costs of home health services and hospice care or benefits for the treatment of and for conditions arising from alcoholism until March, 2005.

Form Number	Form Name
C-006.4-05	Certificate for Policy No.: G46HS12004 Policyholder: FACT

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that the required offer of availability of coverage for hospice care and alcoholism is made in all instances as required by Colorado insurance law.

CLAIMS FINDINGS

Issue J1: Failure to accurately determine the number of days utilized for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

(1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-106.5(3), (4), and (5).

The data being entered into the Company's claim system and used for computing the days from initial receipt of a claim until the check/explanation of benefits is mailed to the claimant (processing time) appears to be producing an incorrect number of days as indicated by the following procedures:

- The received date being entered in the Company's system and used to compute the processing time for claimants belonging to the Sloans Lake Managed Care network is the date the claim is received by Golden Rule after it has been repriced by Sloans Lake, rather than the date of receipt by Sloans Lake.

- The paid date being entered in the Company's system and used to compute the processing time for claims is the date the claim adjudication is completed by the claims adjustor. The check date, later than the paid date, represents the date the check was mailed to the insured or provider and should be the date used for computing processing time. Provider drafts are mailed weekly and insured drafts are mailed daily.

These procedures result in an inability to accurately track the number of days utilized for processing of claims for statistical purposes and to determine in all instances those for which late payment interest and penalties would apply. Carriers cannot avoid their statutory obligations regarding the amount of time allowed for processing claims without interest/penalty being due because an intermediary repricer is involved.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure compliance with Colorado insurance law in accurately determining the number of days required to process claims.

Issue J2: Failure, in some cases, to accurately process claims.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (f)(II) Unfair discrimination: Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (4) Low-dose mammography
>
> (a) … Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index. …
>
> (10) Prostate cancer screening
>
> (a) … Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. …

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

> (1)(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-106.5 (3), (4), and (5).

The Company does not appear to be processing the following types of claims correctly:

- Mammography screening — Lesser of minimum benefit adjusted to reflect increases and decreases in the consumer price index or the actual charge. From 09/01/03 through 08/31/04 = $78.21. From 09/01/04 through 08/31/05 = $81.73.

- Prostate cancer screening Lesser of $65.00 per screening or the actual charge

The Company's processing procedures are based on their belief that the minimum amounts required for the two (2) types of mandated benefits identified above may have plan coinsurance amounts applied even if it results in a benefit that is less than the minimum. Colorado insurance law allows carriers to impose copays and coinsurance on these benefits, however if application would result in a benefit less than minimum, the minimum benefit must be paid.

Randomly selected samples of Paid and Denied claim files were chosen for review of processing from the population of association group claims received from January 1, 2004 through December 3, 2004. The claims cited on the comment forms identified below do not appear to have been processed correctly.

1. Comment Form No. J5
   Four (4) Denied Claims

2. Comment Form No. J5-Second Addendum
   Two (2) Denied Claims

3. Comment Form No. J5-Third Addendum
   One (1) Denied Claim

4. Comment Form No. J5-Fourth Addendum
   One (1) Paid Claim

ASSOCIATION GROUP DENIED CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
32,254	100	7	7%

ASSOCIATION GROUP PAID CLAIMS

Population	Sample Size	Number of Exceptions	Percentage to Sample
110,489	100	1	1%

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104, 10-16-104, and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure that claim procedures are reviewed for accuracy of payment that is in compliance with Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure to reflect complete information in materials dealing with grievance procedures.

Section 10-16-113.5, C.R.S., Independent external review of benefit denials – legislative declaration – definitions, states:

> (6) All health coverage plan materials dealing with the plan's grievance procedures shall advise covered persons in writing of the availability of an independent external review process, the circumstances under which a covered individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.

Amended Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113 (2) and (3) (b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

> Section 2. Purpose and Background
>
> The purpose of this regulation is to set forth guidelines for carrier compliance with the provisions of Section 10-3-1104(1)(h), 10-16-409(1)(a), and 10-16-113, C.R.S., in situations involving utilization review. Among other things, Section 10-3-1104(1)((h), C.R.S., requires carriers to adopt and implement reasonable standards for the prompt investigation of claims arising from insurance policies; promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and refrain from denying a claim without conducting a reasonable investigation based upon all available information.
>
> This regulation is designed to provide minimum standards for handling grievances involving utilization review determinations.
>
> Section 3. Applicability and Scope
>
> The provisions of this regulation shall apply to all health coverage plans that base decisions concerning claims in whole or in part based on utilization reviews. …
>
> Section 4. Definitions
>
> F. "Designated Representative" means:
>
> (2) A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, or a proxy; or

(3) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

Section 7. Expedited Utilization Review

E.(2)(b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Section 10. First Level Review

A. A health carrier shall establish written procedures for the review of an adverse determination that does not involve an urgent care request; …

D. *Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7, a covered person may file a grievance with the health carrier requesting a first level review of the adverse determination.* [Emphasis added.]

Amended Regulation 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of § 10-1-109, 10-16-109, 10-16-113 (3) (b) and 10-16-113.5 (4) (d), C.R.S., states:

Section 2. Background and Purpose

The purpose of this regulation is to provide standards for the external review process set forth in § 10-16-113.5, C.R.S., including the approval of independent external review entities.

Section 3. Definitions

For purposes of this regulation, the following definitions apply:

H. "Designated representative" means:

(1) A person, including the treating health care professional or a person authorized by subsection (2) of this subsection H, to whom a covered person has given express written consent to represent the covered person in an external review; or

(2) A person authorized by law to provide substituted consent for a covered person, including but not limited to a guardian, agent under a power of attorney, or a proxy.

Section 4. Applicability and Scope

The provisions of this regulation shall apply to all health coverage plans that base decisions concerning claims in whole or in part based on utilization reviews. This regulation shall not apply to property and casualty contracts. Where a decision concerning a claim is in no way based on utilization review, a carrier is not required to use the specific procedures outlined in this regulation. Nothing in this regulation shall be construed to supplant any appeal or due process rights that a person may have under federal or state law.

Section 5. Notice and Disclosure of Right to External Review

A.(2) The carrier shall include in the required notice a copy of the description of both the standard and expedited external review procedures the carrier is required to provide pursuant to Subsection B, including the provisions in the external review procedures that give the covered person or the *covered person's designated representative the opportunity to submit new information and including any forms used to process an external review*, as specified by the Division of Insurance. [Emphasis added]

Section 6. Request for External Review

B. All requests for external review shall be made in writing to the carrier and *must include a completed external review request form as specified by the Division of Insurance*. [Emphasis added.]

D. All requests for external review *shall include a signed consent, authorizing the carrier to disclose protected health information,* including medical records, concerning the covered person that is pertinent to the external review.[Emphasis added.]

E. A request for external review submitted by the covered person's designated representative *may include new information*, if significantly different from information provided or considered during the internal review process, for consideration by the carrier and the independent external review entity. [Emphasis added.]

Section 8. Standard External Review

A.(1) Except as provided in Paragraph (2) of this Subsection A, the carrier, upon receipt of a complete request for an external review pursuant to Section 6 of this regulation, shall deliver a copy of the request to the commissioner within two (2) working days.

C.(3)(a) The certified independent external review entity shall notify the covered person or the designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to Paragraph (1) of this Subsection C. Within five (5) working days of such a request, the covered person or the designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier.

H.(1) Except as provided in Paragraph (2) of this Subsection H. within thirty (30) working days after the date of receipt of the request for external review by the carrier, the assigned independent external review entity shall provide written notice of its decision to uphold or reverse the carrier's final adverse determination to:

Section 9. Expedited External Review

A.(2) The covered person's or the designated representative's request for an expedited review must include a physician's certification that the covered person's medical condition meets the criteria in Paragraph (1) of this Subsection A.

E. The certified independent external review entity shall notify, electronically, by facsimile, or by telephone followed by a written confirmation, the covered person or designated representative, the health care professional of the covered person, and the carrier of any additional medical information required to conduct the review after receipt of the documentation required pursuant to subsection D of this Section 9. The covered person or designated representative or the health care professional of the covered person shall submit the additional information, or an explanation of why the additional information is not being submitted to the certified independent external review entity and the carrier within two (2) working days of such a request.

In response to the request for a copy of what would be provided to an insured requesting a copy of the full Colorado internal grievance review process in 2004, the Company provided:

1. A January 1, 2004 through February 23, 2004 document = October 1, 2003 version

2. A February 23, 2004 through August 18, 2004 document = February 23, 2004 version

3. An August 18, 2004 through December 31, 2004 document = August 18, 2004 version

These Colorado Grievance and Appeal Procedure documents do not appear to be complete in the following ways. As indicated in 10-16-113.5, the plan coverage materials dealing with the plan's grievance procedures shall advise:

- The availability of an independent external review process;
- The circumstances under which a person may use such a process;
- The procedures for requesting an independent external review;
- The deadlines associated with an independent external review.

INCOMPLETE

First Level Reviews
Versions used January 1, 2004 through August 18, 2004

The time frames within which the covered person or designated representative are required to file a grievance for a first level appeal review is not reflected.

Standard External Review
Version used January 1, 2004 through February 23, 2004

Nothing is reflected to indicate that the request must include a completed external review request form as specified by the Division of Insurance.

The procedures do not reflect that all requests for external reviews shall include a signed consent, authorizing the carrier to disclose pertinent protected health information, including medical records, concerning the covered person.

Nothing is reflected to indicate to the covered person or the covered person's representative that they have the right to submit new information for consideration, if significantly different from previously submitted or considered.

Versions used January 1, 2004 through August 18, 2004

The procedures do not reflect the timeframe of two (2) working days from receipt of request for an external review within which the carrier is to provide the commissioner with a copy of the request.

Nothing is reflected concerning the five (5) working days allowed for a covered person, a representative of the covered person or a health care professional to submit additional medical information if requested by the independent external review entity.

Expedited External Review
Version used January 1, 2004 through February 23, 2004

Nothing is reflected concerning the requirement that a request for an expedited review must include a physician's certificate that the covered person's medical condition meets certain criteria.

The document does not reflect that if additional medical information is requested by the independent external review entity that the covered person, representative or the health care professional of the covered person has two (2) working days of such a request to respond.

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113.5, C.R.S. and Amended Regulations 4-2-17 and 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that complete information is reflected for utilization review in all materials dealing with grievance procedures as required by Colorado insurance law.

Issue K2: Failure to include all required information in written notification of decisions for expedited and first level reviews.

Section 10-16-113, C.R.S., Procedure for denial of benefits – rules, states:

> (1)(a) A health coverage plan shall not make a determination, in whole or in part, that it will deny a request for benefits for a covered individual on the ground that such treatment or covered benefit is not medically necessary, appropriate, effective, or efficient unless such denial is made pursuant to this section.
>
> (4) *All written denials of requests for covered benefits on the ground that such benefits are not medically necessary, appropriate, effective, or efficient shall be signed by a licensed physician familiar with standards of care in Colorado.* [Emphasis added.]

Amended Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.).

Section 10. First Level Review

> D. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Section 6 or 7, a covered person may file a grievance with the health carrier requesting a first level review of the adverse determination.
>
> I. The decision issued pursuant to Subsection G shall set forth in a manner calculated to be understood by the covered person:
>
> (1) The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers".)
>
> J. A first level review decision involving an adverse determination issued pursuant to Subsection G shall include in addition to the requirements of Subsection I:
>
> (2) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Subsection F(2), to the covered person's benefit request;

(4) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

The sample letters used by Encompass Health Management Systems in the notification of utilization review decisions do not appear to be correct in the following ways:

EXPEDITED UTILIZATION REVIEW

Subject of Letter	Determination
First Appeal Review Service Type: CSR	Adverse-Initial recommendation upheld Not medically necessary

1. The letter is not signed by a licensed physician familiar with standards of care in Colorado and reflects only the following: "ENCOMPASS Health Management Systems."

FIRST LEVEL REVIEW

Subject of Letter	Determination
First Appeal Review Service Type: CSR	Adverse-Initial recommendation upheld or modified Not medically necessary

1. There is no indication that the physician evaluating the first level review was a clinical peer or consulted with an appropriate clinical peer or peers. The Colorado Grievance Procedure Notice that accompanies adverse recommendation notifications reflects only that first level appeals will be evaluated by a medical practitioner not involved in the initial denial.

2. There were actual copies of completed notification letters in the Encompass files reviewed and it appears that sometimes not even a name of the physician that evaluated the first level review was reflected and only a credential of "medical doctor" was indicated.

3. There is no statement indicating that the covered person is entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the covered person's benefit request.

4. There is no explanation of the scientific or clinical judgment for making the determination applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request.

Subject of Letter	Determination
First Appeal Review Review Type: Original Concurrent	Reversed-Full Certification

1. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults are not reflected.

The sample letters used by UnitedHealthcare Care Management in the notification of utilization review decisions do not appear to be correct in the following ways:

EXPEDITED UTILIZATION REVIEW

Subject of Letter	Determination
Urgent Appeal Outcome Upheld	Adverse-Not medically necessary
Urgent Appeal Partial Recommendation	Adverse-Not medically necessary with Partial Recommendation

1. The letters are not signed by a licensed physician familiar with standards of care in Colorado and reflect only the following: "CARE Programs, an Affiliate of UnitedHealthcare."

FIRST LEVEL REVIEW

Subject of Letter	Determination
First Appeal Outcome Upheld	Adverse-Not medically necessary

1. The letter reflects: "If you disagree with our recommendation, you have the right to an appeal of this recommendation by submitting a request in writing with 180 days of receipt of this notification," … One hundred eighty days is the time period allowed a covered person to file for a first level review of an adverse determination. If the first level review is an adverse determination and Golden Rule does not offer a voluntary second level review, the option left for the covered person is an External Review of Benefit Denials. A time period of sixty (60) calendar days after the date of receipt of notice of a carrier's final adverse determination, is allowed for filing a request for an external review with the carrier.

2. As an External Review of Benefit Denials is the next step after an adverse determination on the first level review, the letter should state that an appeal of the recommendation should be directed to Golden Rule Insurance Company instead of the address for UnitedHealth Group Care Programs in Baltimore, MD.

3. The letter is not signed by a licensed physician familiar with standards of care in Colorado, and reflects only the following: "Sincerely, CARE Programs, an Affiliate of UnitedHealthcare."

Subject of Letter	Determination
First Appeal Outcome Partial	Adverse-Not medically necessary with Partial Recommendation

1. The letter reflects: "If you disagree with our recommendation, you have the right to an appeal of this recommendation by submitting a request in writing with 180 days of receipt of this notification," …. One hundred eighty days is the time period allowed a covered person to file for a first level review of an adverse determination. If the first level review is an adverse determination and Golden Rule does not offer a voluntary second level review, the option left for the covered person is an External Review of Benefit Denials. A time period of sixty (60) calendar days after the date of receipt of notice of a carrier's final adverse determination, is allowed for filing a request for an external review with the carrier.

2. As an External Review of Benefit Denials is the next step after an adverse determination on the first level review, the letter should state that an appeal of the recommendation should be directed to Golden Rule Insurance Company instead of the address for UnitedHealth Group Care Programs in Baltimore, MD.

3. The letter is not signed by a licensed physician familiar with standards of care in Colorado, and reflects only the following: "Sincerely, CARE Programs, an Affiliate of UnitedHealthcare."

4. The letter does not reflect the name, title and qualifying credentials of the physician evaluating the appeal and the qualifying credentials of the clinical peer(s) with whom the physician consulted.

Subject of Letter	Determination
Appeal Outcome Overturned	Overturned/Certified

1. The letter does not set forth the name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consulted.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113, C.R.S. and Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all information is included in written notification of decisions for expedited and first level reviews as required by Colorado insurance law.

Issue K3: Failure to provide correct information concerning voluntary second level reviews.

Amended Regulation 4-2-17, Prompt Investigation Of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states:

> Section 10. First Level Review
>
> (7) If the carrier does not offer a voluntary second level review, a description of the procedures for obtaining an independent external review of the adverse determination pursuant to insurance regulation 4-2-21.
>
> Section 11. Voluntary Second Level Review
>
> A. A carrier may establish a voluntary review process to give those covered persons who are dissatisfied with the first level review decision the option to request a voluntary second level review, at which the covered person has the right to appear in person at the review meeting before designated representatives of the carrier. …

The Company has indicated that it has chosen not to offer a voluntary second level review, thereby going directly from a first level review adverse decision to an option for the insured to obtain an independent external review.

The following documents, that accompany adverse recommendation notifications of first level reviews, both incorrectly state that there is an option for the insured of a second level review. Providing incorrect information to the insured and/or provider could cause confusion and problems in not meeting the time period for requesting an independent external review.

Colorado Grievance Procedure Notice Form No. 34471R	Used by Encompass Health Management Systems
Golden Rule Insurance Company Appeal Process for Colorado Form No. CO – Insert	Used by UnitedHealthcare Care Management

The wording on page 1 of the Colorado Grievance Procedure Notice is:

Internal Grievance Review:

> **Standard Internal Grievance Reviews:** First-level appeals will be evaluated by a medical practitioner not involved in the initial denial. Written notice of the first-level appeal decision will be provided within 20 working days of receipt of the written appeal request. *Second-level appeals will be conducted by a different medical practitioner who was not involved in the original denial or the first-level appeal and who practices in a field of medicine appropriate to the grievance.*

Written notice of the second-level appeal decision will be provided within 20 working days of receipt of the appeal request. [Emphasis added.]

Independent External Review: After completing all levels of internal review, *the covered person may, within 60 days after receiving notice of the second-level internal appeal denial,* request an independent external review by filing a request with the Golden Rule Grievance Administrator at the address stated above. [Emphasis added.]

The wording on page 2 of the Golden Rule Insurance Company Appeal Process for Colorado is:

Voluntary Second Level Review Process	If you are not satisfied with the first level of review, *you or your representative may request a second level review within 30 days of the first level review decision* by contacting Golden Rule Insurance at: 7440 Woodland Drive, Indianapolis, IN 46278. [Emphasis added.] You or your representative may also request an external review (see External Review section below) by contacting Golden Rule Insurance Company at: 7440 Woodland Drive, Indianapolis, IN 46278.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that information provided to insureds and/or providers concerning grievance procedures reflects accurate information as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

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